

1 EDMUND G. BROWN JR.
Attorney General of California
2 ARTHUR D. TAGGART
Supervising Deputy Attorney General
3 LESLIE A. BURGERMYER
Deputy Attorney General
4 State Bar No. 117576
1300 I Street, Suite 125
5 P.O. Box 944255
Sacramento, CA 94244-2550
6 Telephone: (916) 324-5337
Facsimile: (916) 327-8643
7 *Attorneys for Complainant*

8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2010-163

12 **JUDY YVONNE WHITE, a.k.a.**
13 **JUDY YVONNE GROSS**
2058 Pasado Avenue
14 Manteca, CA 95336

A C C U S A T I O N

15 Registered Nurse License No. 418904

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

20 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her
21 official capacity as the Interim Executive Officer of the Board of Registered Nursing,
22 Department of Consumer Affairs.

23 2. On or about August 31, 1987, the Board of Registered Nursing issued Registered
24 Nurse License Number 418904 to Judy Yvonne White (Respondent). The Registered Nurse
25 License was in full force and effect at all times relevant to the charges brought herein, and
26 expired on April 30, 2007, and has not been renewed.

27 ///

28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
84

2
3

4
5

6
7
8

9
10
11

12

13

14

15

16
1718
19
20

22

2.2.4

2.2

2

1 10. Health and Safety Code section 11173 provides, in pertinent part:

2 (a) No person shall obtain or attempt to obtain controlled substances, or
3 procure or attempt to procure the administration of or prescription for
4 controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge;
5 or (2) by the concealment of a material fact.

6 (b) No person shall make a false statement in any prescription, order,
7 report, or record, required by this division.

8 **DRUGS**

9 11. **Marijuana** is a Schedule I controlled substance as designated in Health and
10 Safety Code section 11054, subdivision (d)(13).

11 12. **Morphine/Morphine Sulfate** is a Schedule II controlled substance as
12 designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

13 13. **Vicodin** is a trade name for **Hydrocodone** and is a Schedule III controlled
14 substance as designated in Health and Safety Code section 11056, subdivision (e)(4).

15 **COST RECOVERY**

16 14. Section 125.3 of the Code provides, in pertinent part, that the Board may
17 request the administrative law judge to direct a licensee found to have committed a
18 violation or violations of the licensing act to pay a sum not to exceed the reasonable costs
19 of the investigation and enforcement of the case.

20 **FIRST CAUSE FOR DISCIPLINE**

21 (False, Grossly Incorrect, Grossly Inconsistent, or Unintelligible Entries
22 in Hospital, Patient or Other Records)

23 15. Respondent's license is subject to disciplinary action under Code section 2761,
24 subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,
25 subdivision (e), in that on or about and between February 5, 2006, and March 28, 2006, while
26 employed by Mark One Corporation, and on duty as a Registered Nurse at Bel Air Lodge
27 Convalescent Home, Turlock, California, and Ha'Le Aloha Convalescent Hospital, Ceres,
28 California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible

1 entries in hospital, patient or other records pertaining to the controlled substances Vicodin and
2 Morphine/Morphine Sulfate (MS), as follows:

3 **Patient A:**

4 a. On March 17, 2006, Respondent withdrew one Vicodin tablet at 1200 hours and one
5 Vicodin tablet at 1400 hours from the Hospital's Controlled Drug Accountability Record
6 (CDAR) under the name of Patient A. Respondent charted the administration of one Vicodin
7 tablet at 1200 hours in the patient's Medication Administration Record (MAR) but failed to chart
8 the administration of one Vicodin tablet in the patient's MAR. Respondent failed to chart the
9 administration of the two Vicodin tablets or otherwise account for the administration,
10 disposition, or waste of the tablets in the nurses progress notes or nurses medication notes for the
11 patient.

12 b. On March 21, 2006, Respondent withdrew one Vicodin tablet at 1200 hours and two
13 Vicodin tablets at 1700 hours from the Hospital's CDAR under the name of Patient A.
14 Respondent charted the administration of one Vicodin tablet at 1200 hours and one Vicodin
15 tablet at 1800 hours in the patient's MAR but failed to chart the administration, disposition, or
16 waste of one Vicodin tablet in the MAR. Respondent failed to chart or otherwise account for the
17 administration, disposition, or waste of three Vicodin tablets in the nurses progress notes or
18 nurses medication notes for the patient.

19 c. On March 24, 2006, Respondent withdrew one Vicodin tablet at 0800 hours and
20 one Vicodin tablet at 1200 hours from the Hospital's CDAR under the name of Patient A.
21 Respondent failed to chart the administration of two Vicodin tablets on the patient's MAR and
22 failed to chart the administration of two Vicodin tablets in the nurses progress notes or the nurses
23 medication notes for the patient.

24 **Patient B:**

25 d. On March 7, 2006, Respondent withdrew one Vicodin tablet at 0800 hours, two
26 Vicodin tablets at 1200 hours and one Vicodin tablet at 1600 hours from the Hospital's CDAR
27 under the name of Patient B. Respondent charted the administration of one Vicodin tablet at
28 0800 hours, one Vicodin tablet at 1200 hours and one Vicodin tablet at 1600 hours in Patient B's
MAR but failed to chart the administration of one Vicodin tablet in Patient B's MAR.
Respondent failed to chart the administration of the four Vicodin tablets in the patient's care

1 record and to otherwise account for the administration, disposition, or waste of the Vicodin
2 tablets.

3 e. On March 23, 2006, Respondent withdrew two cc of MS at 0700 hours, 1000 hours,
4 1200 hours, and 1400 hours from the Hospital's Liquid Drug Report under the name of Patient
5 B. Respondent charted the administration of 2 mg of MS at 0700, 1000 hours, 1200 hours, and
6 1400 hours in the nurses medication notes for the patient. Respondent charted the administration
7 of 2 mg of MS at 0700 hours in the nurses progress notes for the patient but failed to chart the
8 administration of six cc of MS in said notes.

9 f. On March 24, 2006, Respondent withdrew four cc of MS at 0800 hours, 1000 hours,
10 1200 hours, and 1400 hours from the Hospital's Liquid Drug Report under the name of Patient
11 B. Respondent charted the administration of four mg of MS at 0800 hours, 1000 hours, 1200
12 hours, and 1345 hours in the nurses medication notes for the patient. Respondent charted the
13 administration of four mg of MS at 0800 hours and four mg of MS at 1000 hours in the nurses
14 progress notes for the patient but failed to account for the administration, disposition, or waste of
15 eight cc of MS in said notes.

16 g. On March 25, 2006, Respondent withdrew four cc of MS at 0730 hours, 0930 hours,
17 1130 hours, and 1330 hours from the Hospital's Liquid Drug Report under the name of Patient
18 B. Respondent charted the administration of four mg of MS at 0730 hours, 0930 hours, 1130
19 hours, and 1330 in the nurses medication notes for the patient. Respondent charted the
20 administration of four mg of MS at 0700 and four mg of MS at 1330 in the nurses progress notes
21 for the patient but failed to account for the administration, disposition, or waste of eight cc of MS
22 in said notes.

23
24
25 **Patient C:**

26 h. On March 23, 2006, Respondent withdrew one Vicodin tablet at 0700 hours and two
27 Vicodin tablets at 1200 hours from the Hospital's CDAR under the name of Patient C.
28

1 Respondent charted the administration of one Vicodin tablet at 0700 hours and one Vicodin
2 tablet at 1200 hours in the nurses medication notes for the patient but otherwise failed to account
3 for the administration, disposition, or waste of one Vicodin tablet in the Hospital or
4 nurses progress notes for the patient.

5 i. On March 24, 2006, Respondent withdrew one Vicodin tablet at 0800 hours from the
6 Hospital's CDAR under the name of Patient C. Respondent charted the administration of one
7 Vicodin tablet within the period of "7-3" on the patient's MAR but otherwise failed to chart the
8 administration of one Vicodin tablet on the nurses progress notes for the patient.

9 j. On March 25, 2006, Respondent withdrew one Vicodin tablet at 0700 hours and one
10 tablet at 1200 hours from the Hospital's CDAR under the name of Patient C. Respondent
11 charted the administration of one Vicodin tablet at 0700 hours and one Vicodin tablet an 1200
12 hours on the nurses medication notes for the Respondent. Respondent charted the administration
13 of one Vicodin tablet at a non-specific time within the period of "7-3" and one Vicodin tablet at a
14 non-specific time within the period of "3-11" on the patient's MAR but otherwise failed to chart
15 the administration of either of the two Vicodin tablets on the nurses progress notes for the
16 patient.

17 k. On March 28, 2006, Respondent withdrew one Vicodin tablet at 1000 hours from the
18 Hospital's CDAR under the name of Patient C. Respondent charted the administration of one
19 Vicodin tablet at 1000 hours on the nurse medication notes for Respondent. Respondent charted
20 the administration of one Vicodin tablet at a non-specific time within the period of "7-3" on the
21 patient's MAR but otherwise failed to chart the administration of one Vicodin tablet on the nurse
22 progress notes for the patient.

23 **Patient D:**

24 l. On February 3, 2006, Respondent withdrew two Vicodin tablets at 1400 hours from
25 the Hospital's CDAR under the name of Patient D. Respondent charted the administration of
26 Vicodin at a non-specific time within the period of "7-3" and Vicodin tablet at a non-specific
27 time within the period of "3-11" in the patient's MAR but failed to chart the number of Vicodin
28

1 tablets administered. Respondent charted the administration of two Vicodin tablets at 0730
2 hours and two Vicodin tablets at 1400 hours in the nurses medication notes for the patient but
3 failed to chart or otherwise account for the administration, disposition, or waste of four
4 Vicodin tablets in the nurses notes for the patient.

5 m. On February 4, 2006, Respondent withdrew two Vicodin tablets at 0700 hours, two
6 Vicodin tablets at 1100 hours, and two Vicodin tablets at 1500 hours from the Hospital's CDAR
7 under the name of Patient D. Respondent charted the administration of Vicodin at a non-specific
8 time within the period of "7-3" and at a non-specific time within the period of "3-11" in the
9 patient's MAR but failed to chart the number of Vicodin tablets administered. Respondent
10 charted the administration of two Vicodin tablets at 0700, two Vicodin tablets at 1100, and two
11 Vicodin tablets at 1500 hours in the nurses medication notes for the patient but failed to chart or
12 otherwise account for the administration, disposition, or waste of any of the Vicodin tablets in
13 the nurses notes for the patient.

14 n. On February 5, 2006, Respondent withdrew two Vicodin tablets at 0900 hours and
15 two Vicodin tablets at 1300 hours from the Hospital's CDAR under the name of Patient D.
16 Respondent charted the administration of Vicodin at a non-specific time within the period of "7-
17 3" and at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart
18 the number of Vicodin tablets administered. Respondent charted the administration of two
19 Vicodin tablets at 0900 and two Vicodin tablets at 1300 in the nurse medication notes for the
20 patient but failed to chart or otherwise account for the administration, disposition, or waste of
21 any of the Vicodin tablets in the nurses notes for the patient.

22 o. On February 10, 2006, Respondent withdrew two Vicodin tablets at 0700 hours and
23 two Vicodin tablets at 1400 hours from the Hospital's CDAR under the name of Patient D.
24 Respondent charted the administration of Vicodin at a non-specific time within the period of "7-
25 3" and at a non-specific time within the period of "3-11" in the patient's MAR but failed to chart
26 the number of Vicodin tablets administered. Respondent charted the administration of two
27 Vicodin tablets at 0700 hours and two Vicodin tablets at 1400 hours in the nurses medication
28

1 notes but failed to chart or otherwise account for the administration, disposition, or waste of any
2 of the Vicodin tablets in the nurses notes for the patient.

3 **SECOND CAUSE FOR DISCIPLINE**

4 (Obtained, Possessed, Self-Administered Controlled Substances)

5 16. Respondent's license is subject to disciplinary action under Code section 2761,
6 subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762,
7 subdivision (a), in that during the period of February 3, 2006, and October 28, 2008, Respondent
8 obtained or possessed, or administered to herself the controlled substances Marijuana and
9 Vicodin, a follows:

10 a. On or about and between February 3, 2006, and March 28, 2006, Respondent
11 obtained the controlled substance Vicodin while employed by Mark One Corporation and on
12 duty as a Registered Nurse at Bel Air Lodge Convalescent Home, Turlock, California, and
13 Ha'Le Aloha Convalescent Hospital, Ceres, California.

14 b. On or about June 10, 2007, October 10, 2008, and October 26, 2008, Respondent
15 self-administered the controlled substance Marijuana, in violation of Health and Safety Code
16 section 11170.

17 c. On or about October 28, 2008, Respondent possessed the controlled substance
18 Marijuana, in violation of Health and Safety Code section 11170.

19 **THIRD CAUSE FOR DISCIPLINE**

20 (Obtain or Attempt to Obtain Controlled Substances by Fraud, Deceit,

21 Misrepresentation, Subterfuge or Concealment of a Material Fact)

22 17. Respondent's license is subject to disciplinary action under Code section 2761,
23 subdivision (a), on the grounds of unprofessional conduct and in violation of Health and Safety
24 Code section 11173, subdivision (a), in that she obtained or attempted to obtain, procured or
25 attempted to procure the administration of controlled substances by fraud, deceit,
26 misrepresentation, or subterfuge, or by the concealment of a material fact as set forth in
27 paragraphs 15 and 16, above.

28 ///

1 **FOURTH CAUSE FOR DISCIPLINE**

2 (Unprofessional Conduct)

3 18. Respondent's license is subject to disciplinary action under Code section 2761,
4 subdivision (a), on the grounds of unprofessional conduct, as set forth in paragraphs 15, 16, and
5 17, above.

6 **PRAYER**

7 **WHEREFORE**, Complainant requests that a hearing be held on the matters herein
8 alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

9 1. Revoking or suspending Registered Nurse License Number 418904, issued to
10 Judy Yvonne White, a.k.a. Judy Yvonne Gross;

11 2. Ordering Judy Yvonne White, a.k.a. Judy Yvonne Gross to pay the Board of
12 Registered Nursing the reasonable costs of the investigation and enforcement of this case,
13 pursuant to Business and Professions Code section 125.3;

14 3. Taking such other and further action as deemed necessary and proper. :

15 DATED: 9/15/09

Louise R. Bailey
LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

16
17
18
19 SA2008305996
20
21
22
23
24
25
26
27
28